Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jul 12, 2018	2018_523461_0008	020342-16, 034101-16, 012191-17, 023944-17, 001305-18, 002518-18, 002999-18, 005882-18	Complaint

Licensee/Titulaire de permis

Vigour Limited Partnership on behalf of Vigour General Partner Inc.
302 Town Centre Blvd Suite 300 MARKHAM ON L3R 0E8

Long-Term Care Home/Foyer de soins de longue durée

Rockcliffe Care Community
3015 Lawrence Avenue East SCARBOROUGH ON M1P 2V7

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

CRISTINA MONTOYA (461), ROMELA VILLASPIR (653)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): May 3, 4, 7-11, 14-18, 22-25, 2018 and June 13-15, 2018

The following intakes were completed in this complaint inspection:
Log # 020342-16 related to medication administration, resident care, dealing with complaints
Log # 034101-16 related to nutrition and hydration, medication administration,

resident care, housekeeping and maintenance, staffing
Log # 012191-17 related to staffing, menu planning, prevention of abuse, dealing with complaints, skin and wound care
Log # 023944-17 related to staffing, resident care, continuity of care, maintenance
Log # 005882-18 related to medication administration, prevention of abuse and neglect, transferring and positioning, continence and bowel management, resident care
Log # 002518-18 related to staffing, social activities program, resident care, infection prevention and control, housekeeping and maintenance
Log # 001305-18 related to falls
Log # 002999-18 related to minimizing of restraints
Log # 012870-18 related to weight assessment

A Written Notification related to Long-Term Care Homes Act, S.O. 2007, s. 6 (1) (c), identified in concurrent inspection #2018_486653_0010 (Log #028426-17) will be issued in this report.

A Written Notification related to O. Reg. 79/10, s. 8 (1) (b), identified in concurrent inspection #2018_486653_0010 (Log #028426-17) will be issued in this report.

During the course of the inspection, the inspector(s) spoke with the residents, Substitute Decision Makers (SDM), Personal Support Workers (PSW), Recreation Assistants (RA), Housekeepers, Dietary Aide, Scheduling Coordinator, Registered Practical Nurses (RPN), Registered Nurses (RN), Registered Dietitian (RD), Occupational Therapist (OT), Physiotherapist (PT), Recreation Program Director, Resident and Family Relations Coordinator, Recreation Program Director, Environmental Services Director, Food Service Manager, Dietary Service Supervisor (DSS), Associate Directors of Care (ADOC), Director of Care (DOC), and Executive Director (ED).

During the course of this inspection, the inspector toured the home; observed staff to resident interactions; conducted dining and snack observations; reviewed clinical health records, staff education records, internal investigations, complaint records, staff schedules, and relevant home policies and procedures.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Responsive Behaviours
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.

7 WN(s)
5 VPC(s)
0 CO(s)
0 DR(s)
0 WAO(s)

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

s. 6. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee had failed to ensure that there was a written plan of care for each resident that sets out clear directions to staff and others who provided direct care to the resident.

The following evidence related to resident #010 were found under inspection report #2018_486653_0010.

The home had submitted Critical Incident System (CIS) report on an identified date. The CIS report indicated that resident #010 had an identified incident which resulted in an injury.

A review of resident #010’s written plan of care on a specified date, identified them at risk for falls and included several interventions related to falls prevention.

Interviews with the two Personal Support Workers (PSWs) who worked on the day of the incident, were unable to recall the details. An interview with Registered Nurse (RN) #129, revealed that on an identified date the PSWs heard resident #010’s identified device activate and they went to their bedroom, and found the resident on the floor. The PSWs called the RN to attend to resident #010, and the RN completed their assessments, with no apparent injuries. The RN further indicated that a number of falls prevention interventions were in placed at the time of the fall.

Observations conducted on identified dates, revealed that the resident had an identified fall safety measure in place.

Interviews with PSW #130 and Registered Practical Nurse (RPN) #123 revealed that resident #010 continued to be at risk for falls and described the current falls interventions in place for resident.

Upon review of resident #010’s current written plan of care with the inspector, RPN #123 indicated that there was no information related to the resident’s risk for falls. Further review of resident #010’s health records by the RPN together with the inspector, revealed that the falls section had been resolved and removed from the written plan of care on an identified date. While the most recent fall risk assessment completed on an identified date, still identified resident #010 at risk for falls. The RPN confirmed that resident #010’s written plan of care failed to provide directions to staff on the use of the falls prevention interventions that were in place.

An interview with the Associate Director of Care (ADOC) #112 acknowledged that resident #010's written plan of care failed to provide directions to staff on the fall prevention strategies in place and the resident's risk of falls. [s. 6. (1) (c)]

2. The licensee had failed to ensure that the resident, the resident’s substitute decision maker, if any, and any other persons designated by the resident or substitute decision maker were given an opportunity to participate fully in the development and implementation of the resident’s plan of care.

The Ministry of Health and Long-Term Care (MOHLTC) ACTIONLine received a complaint on an identified date, related to the care of resident #006 in the home. The

concern was that resident #006's identified assistive device had been removed without the family member's consent.

An interview with resident #006's family member, stated that when they had been notified of an incident related to resident #006 on an identified date, they had asked the registered staff whether the assistive device was in place when the incident occurred. The registered staff told the family member that resident #006 no longer had the assistive device. The family member further indicated that they had not been notified by the home prior to removing resident #006's identified assistive device.

An interview with the Physiotherapist (PT) indicated on an identified date, they had assessed resident #006 for identified assistive devices, and deemed that the resident was no longer safe using them. The PT sent a request to remove the identified assistive devices and implemented another intervention instead. The PT further indicated that they could not recall whether they had notified resident #006's family member, and could not confirm that they did, based on their documentation on the resident's health records.

Further review of progress notes, the resident's consent forms, and interviews with the registered staff and the PT did not identify that resident #006's family member had been notified prior to the removal of the assistive devices.

Interview with the Director of Care (DOC) acknowledged the above mentioned information and stated that the home encouraged all family members to be involved in residents' care. The DOC further indicated that the home's expectation was for the staff to inform the family of any changes in the resident's plan of care. [s. 6. (5)]

3. The MOHLTC ACTIONLine received a complaint on an identified date, related to the care of resident #007 in the home. The concerns were that a resident's family member had not provided consent to transfer resident to a different home area and they had also not been notified of a scheduled appointment outside of the home.

A review of resident 007's health records showed that resident was admitted to the home on an identified date with identified medical diagnoses.

A review of resident #007's progress notes for two-and-half month period was carried out and indicated the following:

Resident #007 was relocated from identified room A to identified room B at an identified

date.

Physician ordered an appointment for an outside care provider on an identified date. The RN #152 faxed a referral as ordered. No documentation was found to support that the family member was notified of the referral.

The RPN #153 called resident's family member to notify them of an appointment at an identified date and time, in which family member had responded.

The ED spoke with resident's family member and gave information for the upcoming appointment at an identified date, which was 22 days after the order was written.

The RN #109 received the appointment time and called the family member at an identified date.

In an interview conducted on an identified date, RN #109 indicated that was not aware if the family member was notified of the appointment when it was initially ordered.

On an identified date, the ED provided inspector #461 with a copy of a letter given to resident #007's family member on an identified date, in which they were informed that resident would be relocated to a different home area. The ED confirmed that the mentioned letter was not signed by the family member, and resident #007 was moved to a different home area without the family's consent.

The ED also acknowledged the family member was made aware of resident #007's appointment with the outside care provider on an identified date, but there was no documented evidence suggesting the family member was notified of the appointment on the date the physician ordered it.

The licensee failed to ensure that resident #007's family member was given an opportunity to participate fully in the development and implementation of the resident's plan of care, specifically related to the family member providing consent to transfer resident to a different home area and family member not being notified of an appointment ordered by the physician for resident on an identified date. [s. 6. (5)]

4. The licensee had failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.
The MOHLTC ACTIONLine received a complaint on an identified date, related to an

identified care measure not being followed for resident #007.

A review of resident #007’s medication administration records for an identified three-month period, stated to administer an identified medication at a specified dates and times.

A review of resident #007’s written plan of care on an identified date, the identified person requested that an identified medication was to be given as directed and if there were identified concerns following the medication, the identified person was to be contacted. The intervention was initiated on an identified date, and documented in the written plan of care by RN #145.

A review of resident’s health records for an identified three-month period, revealed that resident’s identified medication was not administered according to physician’s orders.

In an interview conducted on an identified date, the RN #145 said that the identified medication must be administered to resident #007 on an specified date and time, and if it was not effective, then both the resident’s identified person and physician were to be contacted for further direction.

In separate interviews conducted on an identified date, with RPN #110 and RN #104; RPN #110 indicated that the directions to administer the identified medication to the resident were not clear in both the resident #007's electronic Medication Administration Records (e-MARs) and written plan of care.

RN #104 indicated in an interview that resident #007 had an order for an identified medication to be administered at identified dates and times, and an identified person was to be informed before giving the medication to resident. The RN #104 said that the registered staff were expected to document on the health records that resident’s identified person consented to give the medication, but the identified person's instructions were not stated on the resident's e-MARs. RPN #110 and RN #104, both stated that they did not have time to cross-reference the eMAR's orders for the identified medication and the resident's written plan of care when administering the medication to resident, likely resulting in not administering the identified medication to resident #007 as ordered by the physician or requested by the resident’s identified person.

In an interview with RN #109 on an identified date, indicated they did not obtain consent from resident #007’s identified person before administering the medication to resident on

an identified date and time.

In interviews conducted on identified dates, the Executive Director (ED) acknowledged that registered staff were to obtain consent from an identified person before administering the medication to resident and document the consent on the health records. Registered staff had not been administering the medication nor contacting the resident's identified person as specified on the written plan of care or eMAR.

The licensee failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan, related to the administration of an identified medication to resident #007. [s. 6. (7)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident; ensure that the resident's substitute decision-maker is given the opportunity to participate fully in the development and implementation of the resident's plan of care; and ensure the care set out in the plan of care was provided to the resident as specified in the plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee had failed to ensure that any plan, policy, protocol, procedure, strategy, or system that the licensee was required by the Act or Regulation to have instituted or otherwise put in place had been complied with.

According to O. Reg. 49 (1), The falls prevention and management program must, at a minimum, provide for strategies to reduce or mitigate falls, including the monitoring of residents, the review of residents' drug regimes, the implementation of restorative care approaches and the use of equipment, supplies, devices, and assistive aids.

The following evidence related to resident #010 were found under inspection report #2018_486653_0010.

A review of the home's policy titled "Falls Prevention" policy #VII-G-30.00, revised on a specified date, indicated that upon completion of the detailed fall risk assessment, the registered staff or designate will update care plan with associated risk level and interventions.

The home had submitted a CIS report on an identified date and time, related to an incident that caused an injury to a resident for which the resident was taken to hospital and which resulted in a significant change in the resident's health status. The CIS report indicated that on an identified date and time, resident #010 had an incident which resulted in an injury on a specified body part.

A review of resident #010's most recent fall risk assessment completed on an identified date, identified them at risk for falls.

A review of resident #010's written plan of care on an identified period of time, did not identify the resident's level of fall risk and the associated interventions.

An interview with RPN #123 confirmed that the home's expectation was for the registered staff to update the resident's written plan of care with the level of fall risk, and interventions, after completing the fall risk assessment.

An interview with the ADOC confirmed the above mentioned information, and further indicated that the home's policy on falls prevention had not been complied with as the registered staff did not update the written plan of care after the completion of the fall risk

assessment. [s. 8. (1) (a),s. 8. (1) (b)]

2. According to O. Reg. 79/10, s. 69, every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated: a change of 5 per cent of body weight, or more, over one month; a change of 7.5 per cent of body weight, or more, over three months; a change of 10 per cent of body weight, or more, over 6 months; any other weight change that compromises the resident's health status.

The licensee received a written complaint regarding resident #007's care in the home and submitted it to the MOHLTC on an identified date. The complaint indicated that the resident had lost a significant amount of weight within a specified time period.

On an identified date, the complainant indicated that they asked the registered staff about resident #007's weight because the resident had lost a significant amount of weight within a specified time period. The staff provided no explanation.

A review of resident #007's current written plan of care, identified them at nutritional risk. The written plan of care included several nutritional interventions, including weighing resident for a specified time period.

A review of resident #007's weights on the health records revealed a significant weight loss in a 30-day period.

A review of resident #007's progress notes, revealed that on an identified date, the Registered Dietitian (RD) discussed resident's weight loss with the complainant. The weight loss was being investigated and there were several possibilities that may have resulted in the significant weight loss.

On an identified date, daily weight was ordered by the physician for a specified time period.

The resident's health records did not have a reweight recorded on an identified date, nor had weights recorded on identified dates, as per physician's orders. Resident #007 presented a weight loss within an identified time period, with no nutritional assessment or RD referrals identified on the health records from a specified time period, related to the weight loss.

A review of the home's policy titled "Monitoring of Resident Weights", policy #VIIG-20.80, revised on an identified date, directed that all unplanned weight loss or gain of 5% in 30 days, 7.5% in 90 days, or 10% in 180 days, and any other weight change that compromises resident's health status will be assessed and evaluated, and documented by a member of the interdisciplinary care team. The policy directed:

The RN/RPN will ensure that monthly weights or re-weights are documented in the weights and vitals section of the electronic record by the 10th of every month; ensure that the PSW reweighs the resident if there is a weight change (loss or gain) or 2 Kg difference in resident's weight from the previous month; investigate potential causes of weight variance, including a review of resident's current eating patterns, hospitalizations within the past month, and related symptoms and observations; refer to the Dietitian if necessary; update care plans as needed with approval of resident and notification of SDM as needed.

The PSW will immediately reweigh any resident with a weight variance (from previous month) of 2 kg; report variances to registered staff immediately.

In interviews conducted on an identified date, PSW #146 indicated that they had weighed resident #007 on an identified date, and reported the difference to the charge nurse. The PSW said that management had directed them to wait for the nurse's direction to complete a reweigh on the same day of the weight discrepancy, because they could not make that decision on their own.

The ADOC #112 indicated that was notified about the weight loss when the home received the written complaint. The registered staff should have reweighed resident on the same date the weight loss was identified. The ADOC #112 confirmed that the registered staff did not record a reweight for resident #007 until six days later, and the weights on two identified dates were not recorded as per physician's orders.

In an interview conducted on an identified date, the RD indicated that they had called the complainant on an identified date, and explained the staff was investigating possible reasons for the weight discrepancies. The RD said there were no changes to resident's eating patterns and no new interventions were necessary.

In interviews conducted on an identified date, the Dietary Service Supervisor (DSS) #150 indicated that the Dietary Department had not received referrals for the RD related to

resident #007's weight loss during a specified time period.

The ED confirmed that the staff did not follow the home's policy related to monthly weight monitoring. The home's expectation was for the registered staff to have resident #007 reweighed immediately when a weight discrepancy was identified and initiated a referral to the Registered Dietitian.

The licensee failed to ensure that the policy titled "Monitoring of Resident Weights", policy #VII-G-20.80, was complied with, specifically related to resident #007 not being immediately reweighed when a weight variance from the previous month was greater than two kgs, and a referral not being sent to the Registered Dietitian to assess the weight loss. [s. 8. (1) (a),s. 8. (1) (b)]

3. According to O. Reg. 79/10, s. 15 (1) (a). Every licensee of a long-term care home shall ensure that there is an organized program of housekeeping for the home.

The MOHLTC ACTIONLine received a complaint on an identified date, the complainant indicated the home's dining rooms, hallways and walls in the common areas were not properly clean.

The Inspector conducted observations of the home's common areas as follows:

On identified dates and times, there were five storage carts containing Personal Protective Equipment (PPE) intended for residents #012, #013, #014, #015 and #018. The storage carts were located outside the above mentioned residents' rooms, all carts were covered with build-up dust and dry debris.

The hallway floors on all the home's floors (ground, first, second, third) were unclean and covered with a thick film. The baseboards and railings had a built up of dust. The walls appeared with stains from spilled fluids, particularly on the ground floor. The dining room floor on the third floor was not cleaned.

On an identified date and time, the floors and the walls on the second and third floors' dining rooms were dirty, covered with dry debris from spilled beverages and food.

On an identified date and time, the shower room walls on the second and third floor had a thick film, the grout had a build-up of black debris and had an identified odor. The Housekeeper #122 indicated that the shower rooms on the third floor had not been deep

cleaned for an identified time period. In the second floor, the bath tub had a build-up of dust, contained empty dirty shampoos bottles. The walls of the shower had a build-up of a black debris in the tile grout, there was also a dirty mop brush on the shower floor.

On an identified date and time, the shower room on the ground floor had an identified odor, the paint was peeling off the wall and the ceiling above the shower; on the third floor between two identified rooms, the paint was peeling off the wall along the baseboard on the corridor, which could not be thoroughly cleaned or properly sanitized.

A review of the home's policies related to housekeeping and laundry, indicated:
- Cleaning Protocols: Policy # XII-D-10.00, revised on an identified date, directed that cleaning and sanitizing of all equipment and furnishing in the home will be completed in accordance with established best practice guidelines. The housekeeping staff will sign off any required forms or checklists.
- Deep Cleaning of Common Areas - Housekeeping, policy # XII-D-10.90, revised on an identified date, directed that all common areas should be deep cleaned at least weekly. The housekeeping staff will thoroughly clean into corners and baseboards and sign off on checklist.
- Cleaning Frequencies - Housekeeping: Policy # XII-D-10.50, revised on an identified date, indicated that an effective system will be in place to ensure adequate and appropriate cleaning of the home and equipment. This process will include both common spaces and resident spaces. The policy directs that the Environmental Services Manager will monitor for compliance by completing environmental audits and daily rounds; and the Housekeeping staff will complete follow up from environmental audits as directed by the Environmental Services Manager.

In separate interviews conducted on an identified date, with housekeepers #122 and #121; housekeeper #122 reported to be responsible for the deep cleaning of the home's common areas, including shower rooms and dining rooms. Housekeeper #122 reported that they had just returned from an identified leave, and was upset the shower rooms and dining rooms were very dirty upon their return. Housekeeper #121, indicated that in the identified time period, the full time staff responsible for the deep cleaning of the home's dining rooms and showers was on a leave, and the cleaning of those home areas was not properly completed.

In separate interviews conducted on an identified date, three housekeepers #121, #122 and #135, indicated that they did not have check lists to sign off the completion of the cleaning of common areas including shower rooms, dining rooms, and hallways.

Housekeeper #135 said check lists had not been provided by the Director of Environmental Services (DES) in the last six months.

In an interview conducted on an identified date, the Director of Environmental Services (DES) reported that they had no check lists signed off by the part-time housekeeping staff to verify the completion of the home's common areas as per stated in the "cleaning frequencies - housekeeping" policy.

An interview conducted on an identified date, with the ADOC #112, indicated that the home was on an identified outbreak for an identified time period, and provided a copy of the Home's Infection Prevention and Control (IPAC) Plan to prevent outbreaks. Under the "Cleaning and Disinfection" action item, the Environmental Manager was expected to complete weekly audits to ensure cleaning of the home was consistent.

In an interview conducted on an identified date, with DES and ED, the DES confirmed that there were no checklists being completed by the staff as per specified on the "cleaning protocols", "deep cleaning of common areas" and the "cleaning frequencies for housekeeping" policies. The DES acknowledged that they had not provided the housekeeping staff with checklists to verify the completion of their cleaning duties nor had they completed audits in a while for the cleaning and infection control purposes.

The Executive Director indicated that the DES was diligent at completing daily observations throughout the building, but had not provided the housekeeping staff with check lists to acknowledge that the cleaning of the home's common areas had been completed.

The licensee failed to ensure the home's "cleaning protocols", "deep cleaning of common areas" and the "cleaning frequencies for housekeeping" policies were complied with, specifically with the cleaning of the home's common areas. [s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that any plan, policy, protocol, procedure, strategy, or system that the licensee was required by the Act or Regulation to have instituted or otherwise put in place had been complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee had failed to ensure that the home, furnishings and equipment are kept clean and sanitary.

The MOHLTC ACTIONLine received a complaint on an identified date, the complainant indicated the home's dining rooms, hallways and walls in the common areas were not properly clean.

The Inspector conducted observations of the home's common areas as follows:

On identified dates and times, there were five storage carts containing Personal Protective Equipment (PPE) intended for residents #012, #013, #014, #015 and #018. The storage carts were located outside the above mentioned residents' rooms, all carts were covered with build-up dust and dry debris.

The hallway floors on all the home's floors (ground, first, second, third) were unclean and covered with a thick film. The baseboards and railings had a built up of dust. The walls appeared with stains from spilled fluids, particularly on the ground floor. The dining room floor on the third floor was not cleaned.

On an identified date and time, the floors and the walls on the second and third floors' dining rooms were dirty, covered with dry debris from spilled beverages and food.

On an identified date and time, the shower room walls on second and third floor had a thick film, the grout had a build-up of black debris and had an identified odor. The Housekeeper #122 indicated that the shower rooms on the third floor had not been deep cleaned for an identified time period. In the second floor, the bath tub had a build-up of dust, contained empty dirty shampoos bottles. The walls of the shower had a build-up of a black debris in the tile grout, there was also a dirty mop brush on the shower floor.

On an identified date and time, the shower room on the ground floor had an identified odor, the paint was peeling off the wall and the ceiling above the shower; on the third floor between two identified rooms, the paint was peeling off the wall along the baseboard on the corridor, which could not be thoroughly cleaned or properly sanitized.

In separate interviews conducted on an identified date, with housekeepers #122 and #121; housekeeper #122 reported to be responsible for the deep cleaning of the home's common areas, including shower rooms and dining rooms. Housekeeper #122 reported that they had just returned from an identified leave, and was upset the shower rooms and dining rooms were very dirty upon their return. Housekeeper #121, indicated that in the identified time period, the full time staff responsible for the deep cleaning of the home's dining rooms and showers was on vacation, and the cleaning of those home areas was not properly completed.

In separate interviews conducted on an identified date, three housekeepers #121, #122 and #135, indicated that they did not have check lists to sign off the completion of the cleaning of common areas including shower rooms, dining rooms, and hallways. Housekeeper #135 said check lists had not been provided by the Director of Environmental Services (DES) in the last six months.

In an interview conducted on an identified date, the Director of Environmental Services (DES) reported the housekeeper #122 was on a leave for a specified time period and

during this time, the deep cleaning of the common areas had been completed by part-time housekeeping staff members. The DES indicated that housekeeper #122 approached the DES concerned about the uncleanliness of the shower rooms and dining rooms in the home upon return from their leave. The DES said they had not had check lists signed off by the part-time housekeeping staff to verify the completion of the cleaning of the home's common areas.

The licensee failed to ensure the home's common areas were kept clean and sanitary for the above mentioned time period. [s. 15. (2) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home, furnishings and equipment are kept clean and sanitary, specifically to common areas, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 33. PASDs that limit or inhibit movement

Specifically failed to comply with the following:

s. 33. (4) The use of a PASD under subsection (3) to assist a resident with a routine activity of living may be included in a resident's plan of care only if all of the following are satisfied:
1. Alternatives to the use of a PASD have been considered, and tried where appropriate, but would not be, or have not been, effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
2. The use of the PASD is reasonable, in light of the resident's physical and mental condition and personal history, and is the least restrictive of such reasonable PASDs that would be effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
3. The use of the PASD has been approved by,
i. a physician,
ii. a registered nurse,
iii. a registered practical nurse,
iv. a member of the College of Occupational Therapists of Ontario,
v. a member of the College of Physiotherapists of Ontario, or
vi. any other person provided for in the regulations. 2007, c. 8, s. 33 (4).
4. The use of the PASD has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent. 2007, c. 8, s. 33 (4).
5. The plan of care provides for everything required under subsection (5). 2007, c. 8, s. 33 (4).

Findings/Faits saillants :

1. The licensee had failed to ensure that the use of a Personal Assistance Device (PASD) to assist a resident with a routine activity of living was included in the resident #007's plan of care only if all of the criteria required under LTCH Act, 2007, c. 8, s. 33 (4) was satisfied.

The MOHLTC ACTIONLine received a complaint on an identified date, regarding resident #007 not being properly positioned by staff while on an identified mobility device.

A review of resident #007's written plan of care for a specific time period, identified the use of a mobility device as a PASD for comfort and positioning. There was no indication for the use of an additional assistive device as either a PASD or a restraint.

A review of resident’s health care records showed that the Occupational Therapist (OT) #147 assessed resident on an identified date. The OT observed resident #007 had an identified assistive device applied to their mobility device at an identified date and time, which provided better support with positioning. A recommendation was made for resident to use the identified assistive device during identified times.

In an interview conducted on an identified date, the OT #147 confirmed the assessment done for resident #007 on an identified date. The OT spoke with the charge nurse and recommended to apply the identified assistive device to resident #007 at specified times as a PASD to aid with positioning, but did not obtain a consent from a family member for the use of the assistive device at this time.

The RPN #108 who worked on the date the OT assessment occurred was unavailable for an interview.

Inspector #461 conducted observations on identified dates and times related to resident #007’s use of the identified assistive device, which revealed that the assistive device was being applied to the mobility device outside the times recommended by the OT.

In an interview conducted on an identified date, the RPN #110 indicated that resident #007 was unable to stay in an upright position all the time despite having the identified assistive device applied to their mobility device. The RPN #110 was unable to locate either a consent form signed by a family member or an intervention on the written plan of care related to the use of the identified assistive device on resident #007's mobility device.

In an interview conducted with the ADOC #112, indicated the registered staff should have obtained a consent from a family member before using the identified assistive device on resident #007's mobility device. Registered staff was also expected to communicate the interventions to the PSWs and update resident’s written plan of care.

In interviews conducted on identified dates, the RPN #110 further indicated that the ED verbally informed the resident’s family member about the use of an identified assistive device on an unspecified date. The family member thought that the identified assistive device was to be applied to resident #007’s mobility device at times and dates that were different from the OT's recommendations. The family member further indicated that they had not yet signed off a consent form.

The Executive Director (ED), acknowledged the identified assistive device was implemented at different times during the day, before obtaining a consent from resident’s family member.

The licensee failed to include the use of a Personal Assistance Device (PASD) to assist resident #007 with a routine activity of living in the plan of care. [s. 33. (4) 4.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the use of a Personal Assistance Device (PASD) to assist a resident with a routine activity of living may be included in a resident’s plan of care only if all of the criteria required under LTCH Act, 2007, c. 8, s. 33 (4) was satisfied, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee had failed to ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber.

The MOHLTC ACTIONLine received a complaint on an identified date regarding resident #007’s identified medications not being administered as ordered.

A review of resident #007’s medication administration records for an identified three-month period, stated the following orders:

- An identified medication to be administered and the resident to be monitored to maintain the prescribed range.

- An identified medication to be administered at an identified day and time.

A review of resident’s health records for an identified time period and an identified assessment documentation, revealed:

- On an identified date and time, the documented assessment for the resident was below the prescribed range. At this time, resident was receiving the identified medication.

- On an identified date and time, the identified documented assessment for the resident was below the prescribed range, at this time resident was not receiving the identified medication.

A review of resident #007’s health records did not indicate any actions taken by the registered staff to maintain resident #007’s prescribed range of values as per physician’s orders.

In an interview conducted on an identified date, the RN #109 indicated that the assessed value of the resident on an identified date, was likely an error. The RN acknowledged the assessed value was recorded to be below physician’s order, and the RN was expected to take immediate actions to maintain the assessed values as per physician’s orders. The RN #109 confirmed that no actions were taken for resident #007.

The other agency nurse who worked on an identified date, was unavailable for an interview.

In an interview conducted on an identified date, the DOC indicated that the expectation from the staff was to assess the reasons for low levels of the assessed value, ensure resident’s identified medication was properly administered, document on the progress notes, and communicate with the registered staff of the next shift for follow up, which was not done for resident #007. Registered staff were expected to follow the physician’s orders.

A review of resident’s health records for an identified three-month period, revealed that resident’s identified medication was not administered according to physician’s orders.

In an interview conducted on an identified date, the RN #145 said that the identified medication must be administered to resident #007 on an specified date and time, and if it was not effective, then both the resident's family member and physician were to be contacted for further direction.

Interviews conducted on an identified date, the RN #104 indicated that resident #007 had an order for an identified medication to be administered at a specified days and times, and resident's family member wanted to be informed before administering the identified medication to the resident.

The Executive Director (ED) confirmed that the registered staff had not been administering the identified medications as prescribed by the physician nor contacting the resident's family member as specified on the written plan of care.

The licensee failed to ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber, specifically to two identified medications for resident #007. [s. 131. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee had failed to ensure that a person who had reasonable grounds to suspect that abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm occurred or may occur, immediately reported the suspicion and the information upon which it was based to the Director.

The MOHLTC ACTIONLine received a complaint on an identified date and time, in which resident #005 reported that a staff member was forceful when assisting with dressing on an identified date. The home submitted a Critical Incident Report (CIR) on an identified date, related to the allegation of abuse.

In an interview conducted on an identified date, the DOC indicated that resident #005 reported the allegation of abuse on an identified date, but the CIR was not submitted to the Director until four days later, for reasons the DOC could not remember. An investigation carried out by the DOC and ADOC #112 concluded that the allegation was unfounded. The DOC indicated that any allegation of abuse must be reported to the Director immediately, which did not occur with resident #005's allegation.

The DOC confirmed that resident #005's allegation of abuse from a staff member had not being immediately reported to the Director. [s. 24. (1)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).
(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).
(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).
(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that a documented record is kept in the home that includes, the nature of each verbal or written complaint; changes to resident’s; the date the complaint was received; the type of action taken to resolve the complaint; the final resolution, if any; every date on which any response was provided to the complainant and a description of the response; and any response made in turn by the complainant.

The licensee submitted to the MOHLTC written complaints on identified dates regarding resident #007's care in the home. In a phone interview, the complainant indicated that the ED was responding to their concerns by a written response sent by registered mail to their home, and was refusing to meet with the complainant to review the response to their concerns.

A review of the home’s Complaint Log and the Complaints Management Binder from an identified time period, indicated the following:

The complainant submitted a complaint to the home on an identified date, related to their dissatisfaction with the meeting held with the ED on an identified date. A written response was provided to the complainant on an identified date.

The complainant submitted a complaint to the home related to medication administration on an identified date. A written response was provided to the complainant within 10 business days.

The complainant submitted a complaint to the home related to an identified concern, which was documented as an ongoing concern.

The Complaint Log did not describe the nature of the complaint (i.e. verbal or written complaint), a follow up date to the response to the complainant, and any response made by the complainant for the above mentioned complaints. The Complaint Management Binder did not include the home's investigation of the complaints.

A review of the home's policy "Complaints Management Program" policy #XXIII-A-10.40, last revised October 2017, directed the ED or designate related to written complaints to:

- Contact or arrange to meet with the complainant to obtain information about the area (s) concern.
- Conduct and document an internal investigation using the Complaint Record Form and ensure documentation includes: nature of the written complaint, date complaint was received, type of action taken to resolve complaint, including date of action, time frames for actions, and any follow-up action required, final resolutions, every date on which any response was provided to the complainant and description of the response, and any response made by complainant.

For all complaints, the ED or designate will file the complaint information, complaint record, and any other investigation notes in the Complaints Management Binder.

In interviews conducted on a identified dates, the RFRC #126 and the ED confirmed that no meeting had occurred with the complainant to review the above mentioned written complaints in the last 18 business days.

The licensee failed to ensure that a documented record of complaints is kept on the home; specifically every date on which any response was provided to the complainant and a description of the response; and if any response made in turn by the complainant. [s. 101. (2)]

Issued on this 3rd day of August, 2018

Signature of Inspector(s)/Signature de l’inspecteur ou des inspecteurs

Original report signed by the inspector.